DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DAILY CONTROLLED DRUG AND KEY INVENTORY FORM** REFERENCE NO. 702.2

Provider Agency: _____ ALS Unit: _____

DATE	TIME	MIDAZOLAM 5 mg/1 ml maximum 8 unit dose				MORPHINE SULFATE 4 mg/1 ml maximum 15 unit dose				FENTANYL 100 mcg/2ml Maximum 15 unit doses				SIGNATURE/LICENSE # RELINQUISHING PERSONNEL	SIGNATURE/LICENSE # RECEIVING PERSONNEL
		Start	Out (-)	In (+)	Total	Start	Out (-)	In (+)	Total	Start	Out (-)	In (+)	Total		

SUBJECT: **MONTHLY DRUG STORAGE INSPECTION FORM** REFERENCE NO. 702.2

DEPARTMENT OF HEALTH SERVICES
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SUBJECT: **MONTHLY DRUG STORAGE INSPECTION FORM** REFERENCE NO. 702.2

Provider Agency: _____ ALS Unit: _____

Date/Time Monthly Drug Storage Inspection Form conducted: _____

Verify the following items:	**YES**	**NO**
1. Controlled substances are adequately locked and secured.		
2. Expiration dates were verified. Indicate any expired medications: _____		
3. Controlled substance physical inventory count matches documentation.		
4. All forms are complete and legible including:		
a. RN printed name and signatures and clearly displayed.		
b. Paramedic signatures and license numbers clearly displayed.		
c. Name of drug and amount wasted clearly noted.		
Other Findings:		
Recommendations:		
Actions Taken:		
Comments:		
INSPECTOR'S NAME/TITLE:		
INSPECTOR'S SIGNATURE		